

Medical Licensing Board's Permanent Opioid Rules

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Disclosures

Attorney General's Prescription
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AIT Laboratories Advisory Board

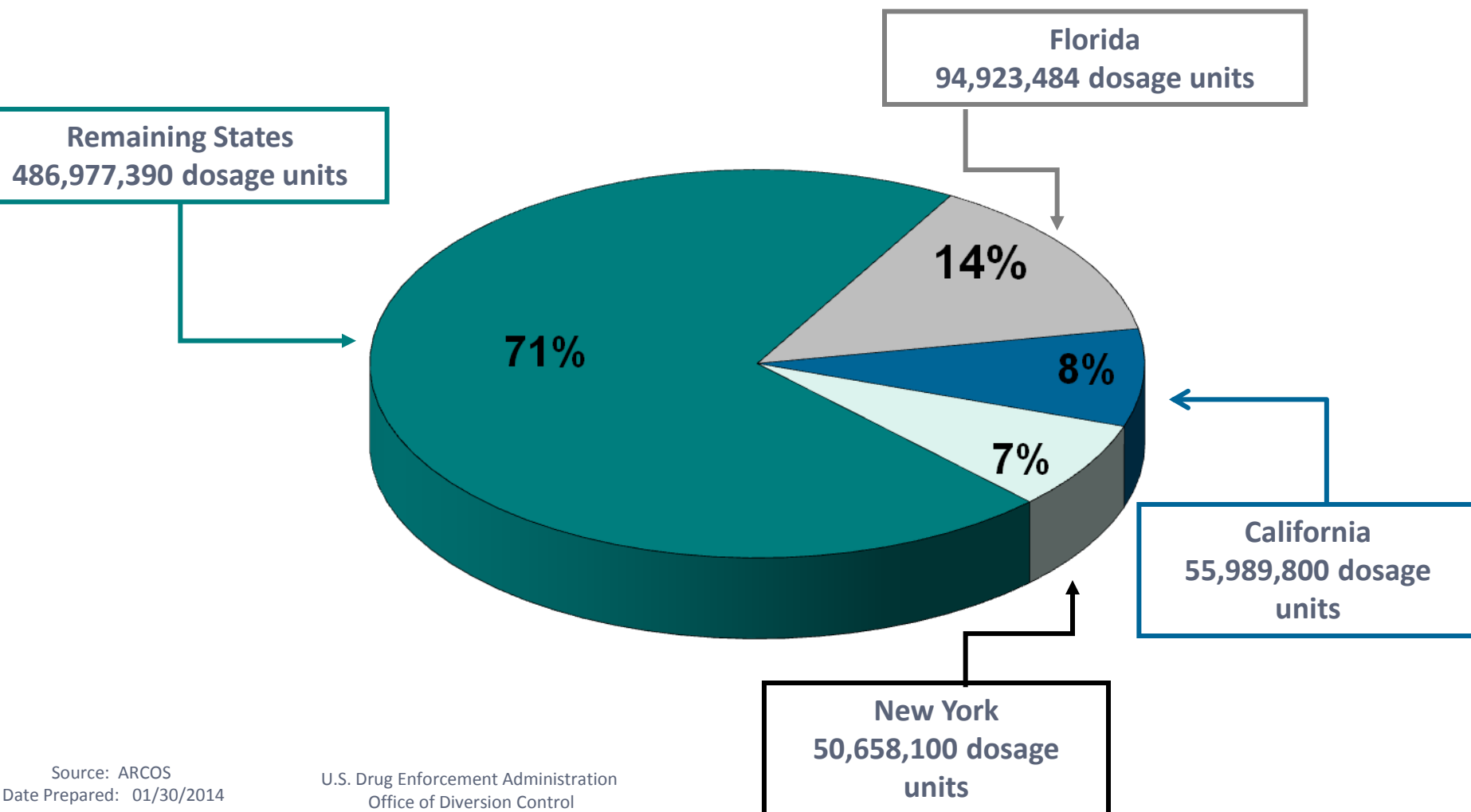


Purchases of Oxycodone 30mg

- In 2009, 44% of all oxycodone 30mg products were distributed to Florida
- In 2010, 43% of all oxycodone 30mg products were distributed to Florida



Nationwide Distribution of Oxycodone 30mg January – December, 2012



Medical License Board Permanent Rules

1. Thou shall diagnosis with appropriate care, get old records
2. Thou shall do psychological assessment
3. Thou shall obtain Risk Stratification
4. Thou shall provide informed consent (**NAS**) and prognosis with Treatment Agreement and functional goals & Exit strategy
 - A. ETOH and opioids admonition/instructions
5. Thou may use **trial** of opioid therapy and modalities
6. Thou shall use a Pain Assessment Tool
7. Thou shall see each 4 months for review
8. Thou shall Risk Stratify and employ drug monitoring, PDMP, pill counts when indicated
9. Thou shall not have paucity of documentation
 - A. Safe Storage of Medications
10. When > 60 MED- formal re-evaluation and education
 - A. Now Includes Tramadol when used > 60 MED

Medical License Board Rules

- Goals are to:
 1. Use opioids with intentionality
 2. Provide greater patient safety
 3. Focus on functionality
 4. Lower pain
 5. Apply to all providers
 - MD, DO, NP and PA

The NEW MLB Rules

Patients that are exempt from Rules include those who are:

- Terminally ill
- Involved with palliative care service
- Managed in a hospice program
- Registered nursing home resident
- *We encourage safety monitoring practices for all patients on chronic opioids*

The Medical Licensing Rules

The MLB rules take effect on December 15, 2013 and apply to:

- Any patient taking >60 opioid pills per month for ≥ 3 months
- Any patient taking a morphine equivalent dose (MED) of >15 mg for ≥ 3 months
- *Non-abuse deterrent sustained release hydrocodone*
- *Transcutaneous opioid patches*
- *Tramadol when > 60 MED*

Healthcare Provider Toolbox: www.bitterpill.in.gov



First Do No Harm:

The Indiana HealthCare Providers Guide to the Safe, Effective
Management of Chronic Non-Cancer Pain

A comprehensive “Clinical
Resource” to assist you in
managing your patients with
chronic pain

Provider Shall

- Appropriately focused H & P
- Review records from previous healthcare providers (if able)
- Patient complete objective pain assessment tool
- Risk Stratification (risk is not static)
- Assess mental health status

Perform your own evaluation

- Take a thorough history
- Perform a targeted physical exam
- Establish a working diagnosis
- Do appropriate tests
- Obtain & review records of past care

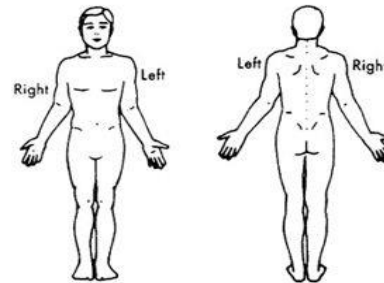
FORM 3.2 Brief Pain Inventory

Date ____ / ____ / ____ Time: ____

Name: Last ____ First ____ Middle Initial ____

- 1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

- 2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.



- 3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain pain as bad as you can imagine

- 4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain pain as bad as you can imagine

- 5) Please rate your pain by circling the one number that best describes your pain on the **average**

0 1 2 3 4 5 6 7 8 9 10
No pain pain as bad as you can imagine

- 6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No pain pain as bad as you can imagine

- 7) What treatments or medications are you receiving for your pain?

- 8) In the Past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received

0% 10 20 30 40 50 60 70 80 90 100%
No Complete
relief relief

- 9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:
A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
interfere interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
interfere interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
interfere interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
interfere interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
interfere interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
interfere interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
interfere interferes

Treatment Agreement

The provider and patient **shall** review and sign a “Treatment Agreement” which shall include the following:

- No sharing: Sharing = trafficking
- Use **Rx** only as written
- Report use of controlled **Rxs** prescribed by other physicians
- ETOH and opioid conversation
- Safe Storage Information
- Copy for Patient and one for your office

Evaluation-Education-Expectation

TREATMENT PLAN

- Explain Key Elements
- Policies and Protocols
- Goals of Treatment
- Tailor Treatments
- Other modalities
- Termination of COT
 - X, Y or Z
 - Exit Strategy
- Truth Telling
 - Controlled substances

INFORMED CONSENT

- Risk : Benefit
 - Addiction
 - Dependence
 - Pain & Function
 - Woman & NAS
- Consent to Monitoring
 - UDM**
 - PDMP
 - Pill counts

Mental Health Assessment – Survey Tools

**Chronic pain may be caused,
influenced or modulated by ...**

- Depression (PHQ-2, -4 and -9)
- Post Traumatic Stress Disorder
- Anxiety/Panic Disorder (GAD-7)

Pain and Mental Illness: Driven to Insane Practices

1. 41.4 million with mental illness
2. 18.9 million Substance Use Disorder
3. 6.8 million mental illness and SUD

2011, NSDUH, SAMHSA

Risk Stratification - Survey Tools

Ask patients about any past or current history of **substance abuse** (alcohol, Rx meds, or illicit) prior to initiating treatment for chronic pain with opioids

- **ORT** – Opioid Risk Tool
- **SOAPP** – Screener/Opioid Assessment for Patients in Pain (starting opioids)
- **COMM** – Common Opioid Misuse Measure (pts already using opioids)

These survey tools will be available at: **www.bitterpill.in.gov**

Rules: Monitoring

Safety and treatment adherence

- PDMP (INSPECT)
 - Initiation and minimum of yearly
- UDM (can use other)
 - Triggered or STD of practice**
 - Jan. 1, 2015
- Pill Count
 - Not mandated to employ
 - Mandated to obtain permission



Kentucky and Rules

KASPER Master Accounts

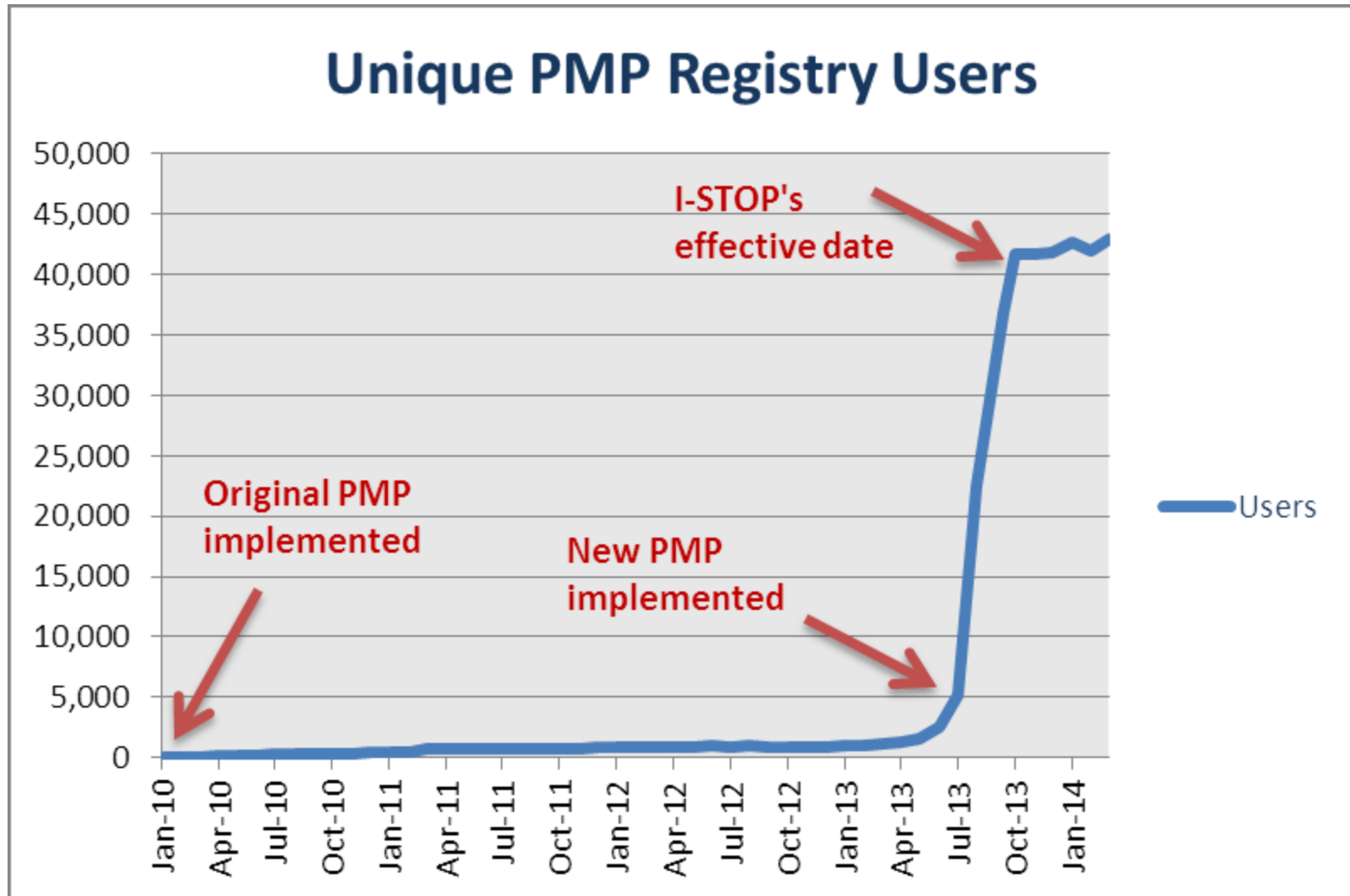
	12/31/2011	04/24/2012	07/20/2012	02/24/2014
Doctor*	5,470	5,680	11,923	17,807
APRN	690	781	1,523	2,150
Pharmacist	1,385	1,450	3,602	5,363
Total	7,545	7,911	17,048	25,320

*Includes physicians, dentists, optometrists and podiatrists

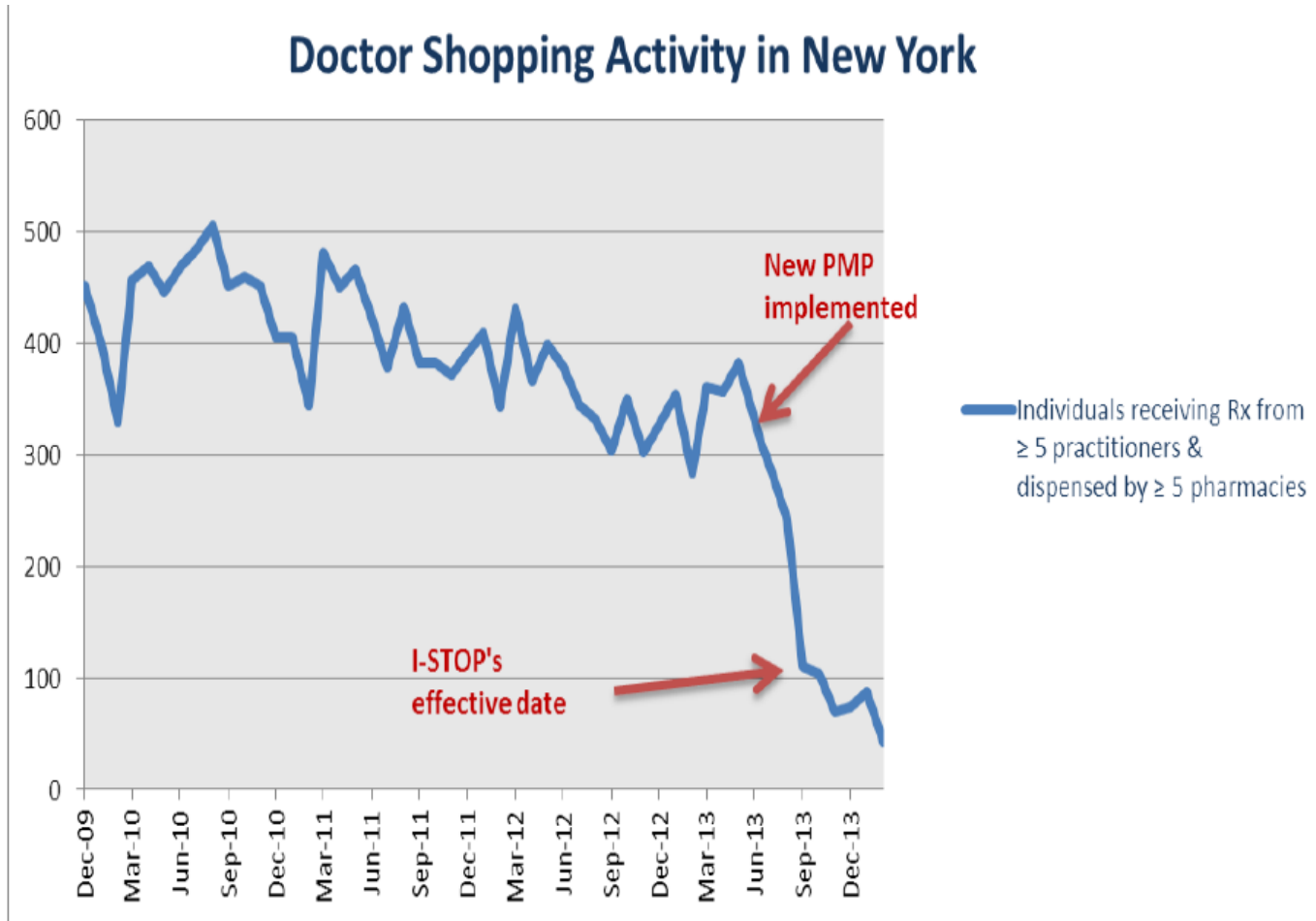
Cabinet for Health and
Family Services



New York and Rules

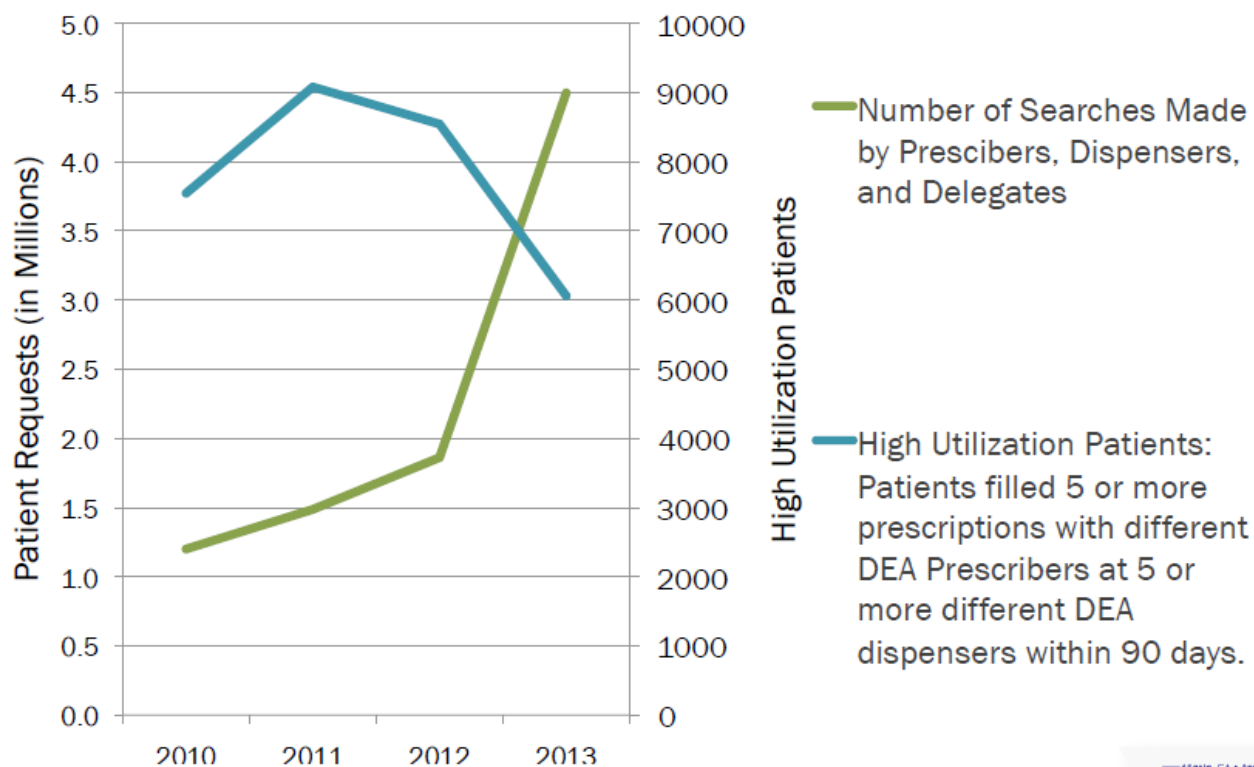


High Users, NY and Rules



Tennessee and Rules

More CSMD Queries, Fewer Doctor Shoppers



Source: Tennessee Department of Health Internal Files, February 2014

“You’re in trouble” or Urine Trouble

Understanding Urine Drug Monitoring

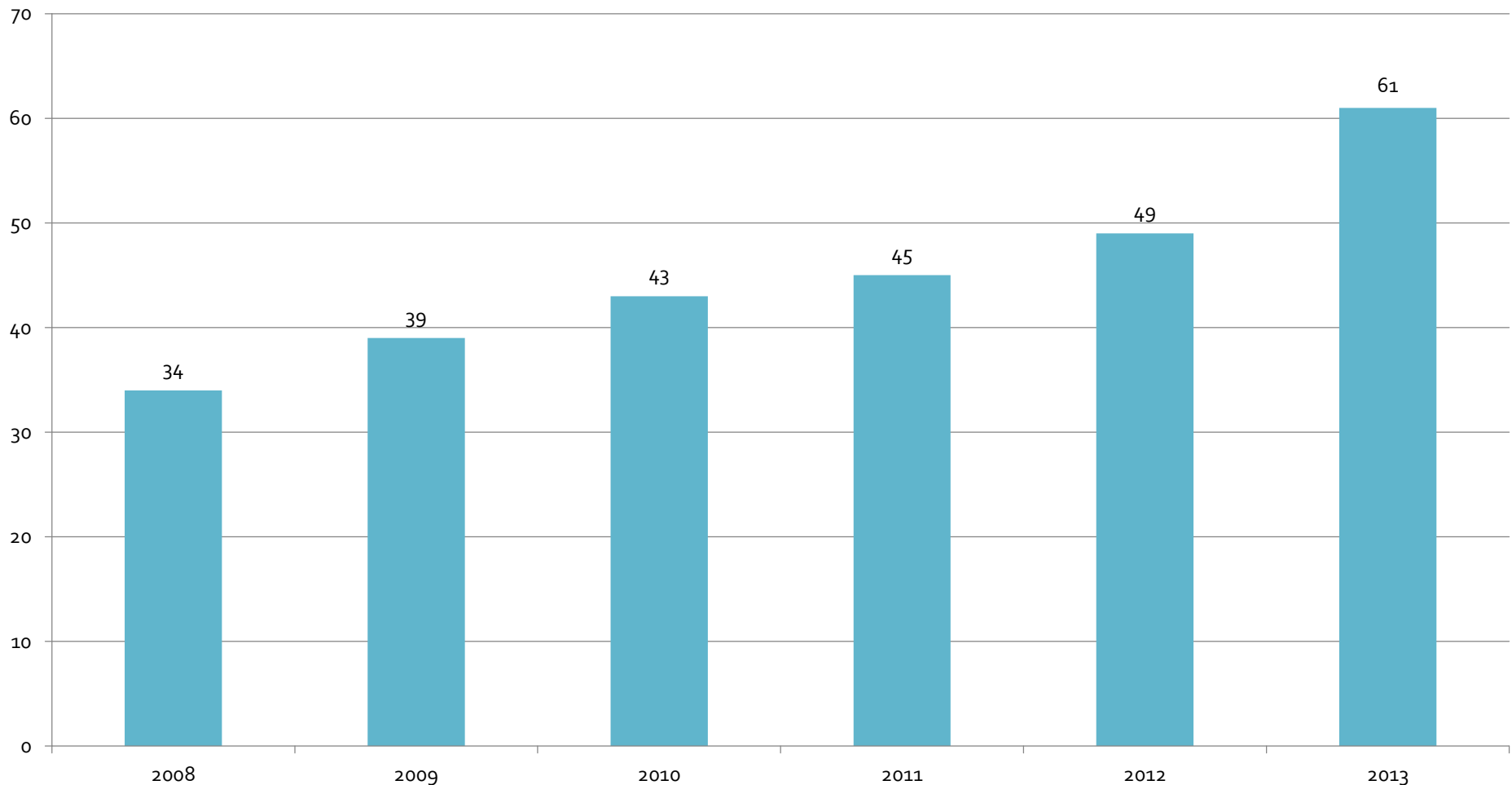
UDM has evolved to become a **standard of care** when prescribing opioids

- Detecting illicit substances
- Monitoring patient adherence to prescribed medications
- UDM should be performed at the initiation of an opioid trial and at least annually
- Interpretation is critical



Overdoses Resulting in Death Allen County, IN 2008-2013

Number of Drug Overdose Deaths with Manner Determined in Allen
County By Year



Functional Goals



Working together with your patient, determine:

Specific
Achievable
Functional Goals

Assess progress at each visit

Reframe expectations: A realistic "Pain Score" target isn't zero!

Prescribing Opiates

***Always have an EXIT strategy!
Don't begin a treatment that you
are not prepared to stop!***



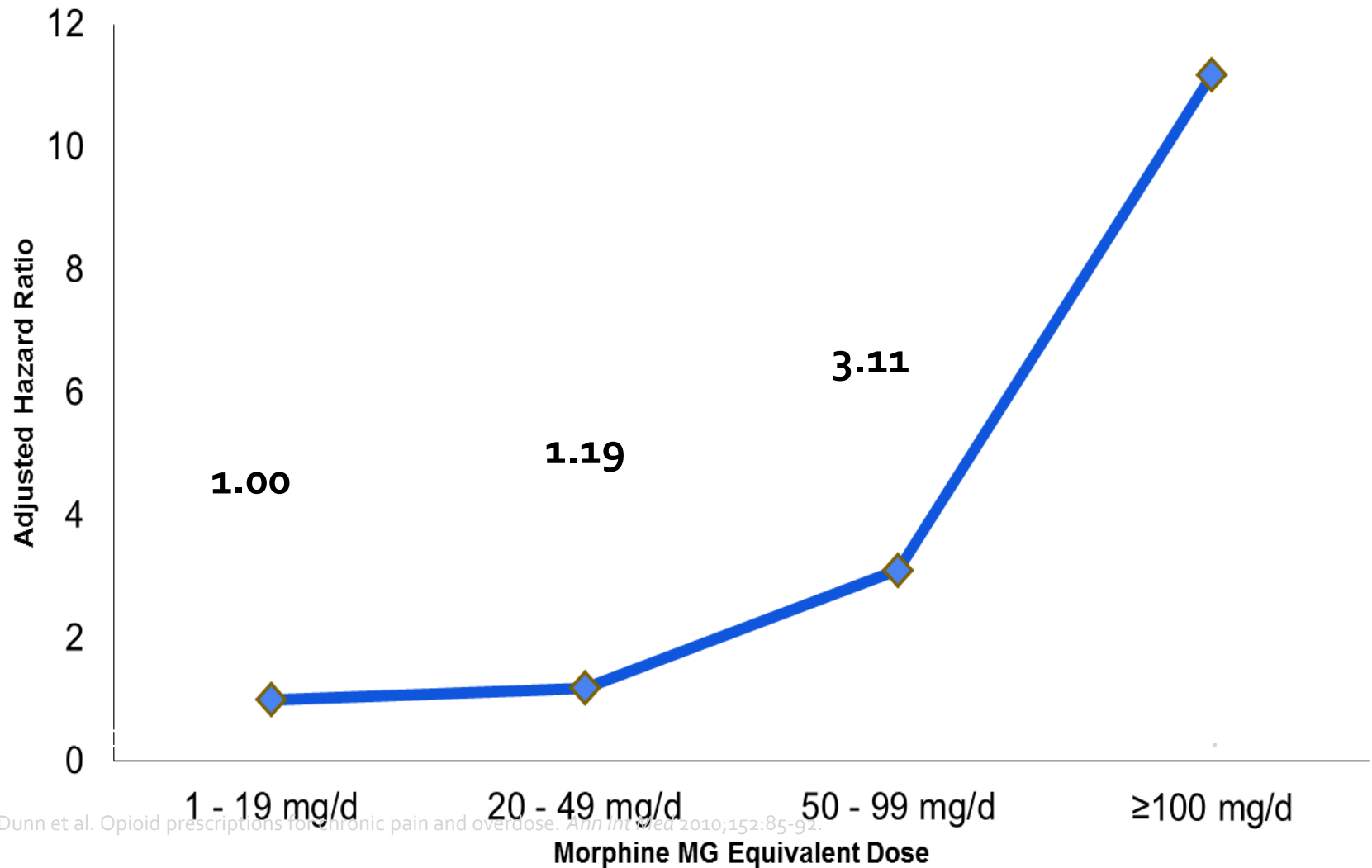
Periodic Scheduled Visits

- Evaluate patient progress
- Monitor compliance
- Set clear expectations
- Q 4mo, if stable (minimum)
- Q 2mo, if changing meds; more often as needed



Activity, **A**nalgesia, **A**ffect, **A**berrancy and **A**DRs

High Opioid Dose and Overdose Risk



Reassessment is required when MED \geq 60 mg/d

- Face-to-face review to reassess your patient
- Tramadol Trigger
- Formulate/document a revised assessment and treatment plan
- Discuss increased risk adverse outcomes (including death) with higher opioid doses
- Specialist referral consideration
 - Addiction, Mental Health, PM&R, Pain

Shift Happens !

Making a Difference: State Successes

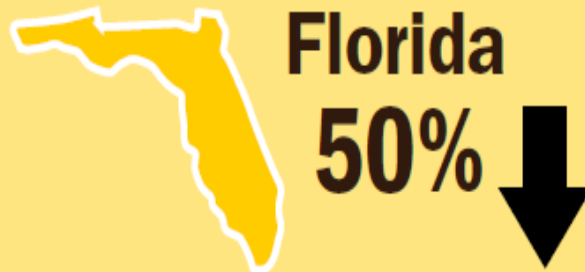


2012 Action:

New York required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

2013 Result:

Saw a **75% drop in patients** who were seeing **multiple prescribers** to obtain the same drugs, which would put them at higher risk of overdose.

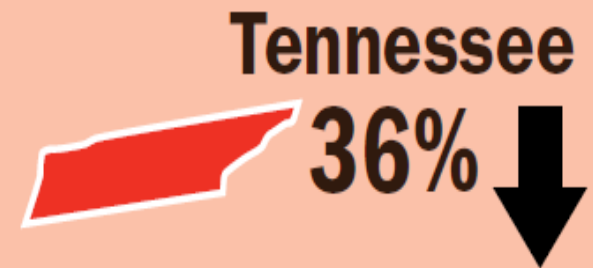


2010 Action:

Florida regulated pain clinics and stopped health care providers from dispensing prescription painkillers from their offices.

2012 Result:

Saw more than **50% decrease in overdose deaths** from oxycodone.



2012 Action:

Tennessee required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

2013 Result:

Saw a **36% drop in patients** who were seeing **multiple prescribers** to obtain the same drugs, which would put them at higher risk of overdose.

“Our prime purpose in this life is to help others.
And if you can't help them, at least don't hurt them”

- Patient Safety is driving force
- Improved Evaluation and Education
- Reduced Addiction and Abuse
- Less Morbidity and Mortality
- A bit more work for all of us

The End

- Palmer MacKie
- pmackie@iu.edu
- Thank you